



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PROS HOME HEALTHCARE INC
2012 BEDFORD RD
BEDFORD TX 76021

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3182-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review all attached information to have claim processed correctly. The insurance company has denied the claim for time limit for filing has expired. The attached information will show proof of timely filing which has also been submitted to the insurance company with the claim denied again following the appeal. The claim should be processed for payment due to claim submitted within the filing limit."

Amount in Dispute: \$1,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The DWC MDR date stamp on the requestor's DWC-60 packet is 5/19/11. The date of 4/2/10 through 4/2/11 is greater than one year. Therefore, DWC MDR has no jurisdiction to proceed with an administrative review of this fee dispute."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2010 through April 2, 2010	CPT Code GO 154	\$1,500.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 22, 2011

- 138 – Appeal procedures not followed or time limits not met.
- 18 – Duplicate claim/service.
- 29 – The time limit for filing has expired.
- 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for service on or after 9/1/05.
- 878 – Appeal (request for reconsideration) previously processed. Refer to rule 133.250(H).
- 879 – Rule 133.250(B) – Health care provider shall submit the request for reconsideration no later than 11 months from the date of service.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute is March 24, 2010, March 25, 2010, March 26, 2010, March 27, 2010, March 28, 2010, March 29, 2010, March 30, 2010, March 31, 2010, April 1, 2010 and April 2, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on May 18, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	December 28, 2011 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.